General Assembly

Raised Bill No. 130

February Session, 2016

LCO No. **1212**

Referred to Committee on PUBLIC HEALTH

Introduced by:
(PH)

AN ACT CONCERNING PATIENT INFORMATION AND THE ALL-PAYER CLAIMS DATABASE.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-1091 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) As used in this section:

(1) "All-payer claims database" means a database that receives and stores data from a reporting entity relating to medical insurance claims, dental insurance claims, pharmacy claims and other insurance claims information from enrollment and eligibility files; and

(2) (A) "Reporting entity" means:

(i) An insurer, as described in section 38a-1, licensed to do health insurance business in this state;

(ii) A health care center, as defined in section 38a-175;

(iii) An insurer or health care center that provides coverage under Part C or Part D of Title XVIII of the Social Security Act, as amended from time to time, to residents of this state;

(iv) A third-party administrator, as defined in section 38a-720;

(v) A pharmacy benefits manager, as defined in section 38a-479aaa;

(vi) A hospital service corporation, as defined in section 38a-199;

(vii) A nonprofit medical service corporation, as defined in section 38a-214;

(viii) A fraternal benefit society, as described in section 38a-595, that transacts health insurance business in this state;

(ix) A dental plan organization, as defined in section 38a-577;

(x) A preferred provider network, as defined in section 38a-479aa; and

(xi) Any other person that administers health care claims and payments pursuant to a contract or agreement or is required by statute to administer such claims and payments.

(B) "Reporting entity" does not include an employee welfare benefit plan, as defined in the federal Employee Retirement Income Security Act of 1974, as amended from time to time, that is also a trust established pursuant to collective bargaining subject to the federal Labor Management Relations Act.

(b) (1) There is established an all-payer claims database program. The exchange shall: (A) Oversee the planning, implementation and administration of the all-payer claims database program for the purpose of collecting, assessing and reporting health care information relating to safety, quality, cost-effectiveness, access and efficiency for all levels of health care; (B) ensure that data received from reporting

entities is securely collected, compiled and stored in accordance with state and federal law; **[**and**]** (C) conduct audits of data submitted by reporting entities in order to verify its accuracy; and (D) develop and implement the use of a form to allow individuals receiving health care services to exclude data relating to such services from the information a reporting entity reports to the all-payer claims database.

(2) The exchange shall seek funding from the federal government, other public sources and other private sources to cover costs associated with the planning, implementation and administration of the all-payer claims database program.

(3) (A) Upon the adoption of reporting requirements as set forth in section 38a-1082, a reporting entity shall report health care information for inclusion in the all-payer claims database in a form and manner prescribed by the exchange. The exchange may, after notice and hearing, impose a civil penalty on any reporting entity that fails to report health care information as prescribed. Such civil penalty shall not exceed one thousand dollars per day for each day of violation and shall not be imposed as a cost for the purpose of rate determination or reimbursement by a third-party payer.

(B) The chief executive officer of the exchange may provide the name of any reporting entity on which such penalty has been imposed to the commissioner. After consultation with said officer, the commissioner may request the Attorney General to bring an action in the superior court for the judicial district of Hartford to recover any penalty imposed pursuant to subparagraph (A) of this subdivision.

(4) The exchange shall: (A) Utilize data in the all-payer claims database to provide health care consumers in the state with information concerning the cost and quality of health care services that allows such consumers to make economically sound and medically appropriate health care decisions; and (B) make data in the all-payer claims database available to any state agency, insurer, employer,

health care provider, consumer of health care services or researcher for the purpose of allowing such person or entity to review such data as it relates to health care utilization, costs or quality of health care services. Such disclosure shall be made in accordance with subdivision (2) of subsection (b) of section 38a-1090. The exchange may set a fee to be charged to each person or entity requesting access to data stored in the all-payer claims database.

(5) The exchange may (A) in consultation with the All-Payer Claims Database Advisory Group set forth in subsection (c) of this section, enter into a contract with a person or entity to plan, implement or administer the all-payer claims database program, (B) enter into a contract or take any action that is necessary to obtain fee-for-service health claims data under the state medical assistance program or Medicare Part A or Part B, and (C) enter into a contract for the collection, management or analysis of data received from reporting entities. Any such contract for the collection, management or analysis of such data shall expressly prohibit the disclosure of such data for purposes other than the purposes described in this subdivision.

(c) (1) There is established a working group to be known as the All-Payer Claims Database Advisory Group. Any member of the working group, as of June 30, 2013, shall continue to serve as a member of said group. Said group shall include, but not be limited to, the Secretary of the Office of Policy and Management, the Comptroller, the Commissioners of Public Health, Social Services and Mental Health and Addiction Services, the Insurance Commissioner, the Healthcare Advocate, the Chief Information Officer, a representative of the Connecticut State Medical Society, representatives of health insurance companies, health insurance purchasers, hospitals, consumer advocates and health care providers. The chief executive officer of the exchange, in concurrence with the chairperson of the exchange, may appoint additional members to said group.

(2) The All-Payer Claims Database Advisory Group shall develop a

plan to implement a state-wide multipayer data initiative to enhance the state's use of health care data from multiple sources to increase efficiency, enhance outcomes and improve the understanding of health care expenditures in the public and private sectors.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2016*	38a-1091

Statement of Purpose:

To allow patients the option of having data relating to health care services they receive excluded from the all-payer claims database.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]